

Application for the Nebraska Specialized Telecommunications Equipment Program

A. APPLICANT INFORMATION

(please print)

NAME: _____
(Last) (First) (Middle Initial)

HOME ADDRESS: _____
(Number and Street Name, or PO Box)

CITY: _____ **STATE:** _____

ZIP: _____ **COUNTY:** _____

DAYTIME PHONE: () _____ **V/TTY/Both**
(circle one)

HOME PHONE: () _____ **V/TTY/Both**
(circle one)

SOCIAL SECURITY NUMBER: _____ - _____ - _____

BIRTH DATE: _____ / _____ / _____

Name of someone who can help us contact you: (a person not living with you). NOTE: If mail address is different than the applicant's address, complete this section and check here: _____ .

NAME: _____ **PHONE:** () _____ **V/TTY/Both**
(circle one)

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

B.

EQUIPMENT NEEDS

Part 1 – Telephone Equipment – (Please Check Only One)

☐ Computer Conversion Package (TTY modem only)

☐ Phone with Amplification (Built-in)

Additional application required:

☐ Phone Amplifier

☐ Large Visual Display

☐ Tactile Ring Signaler

☐ Telebrailer

☐ TTY/TT (with 6 rolls of paper maximum)

☐ Voice Carry Over (VCO) Phone

Check if Setup is required: ☐

☐ Other (please specify) _____

Part 2 – Phone Signaling Devices – (Please Check Only One)

☐ Light Signaler Phone Ring – Master

_____ Number of remote receivers needed (Limit of 2)

☐ Phone Ringer

☐ Personal Vibrator

☐ Other (What Kind – example, “Alertmaster”) _____

C.

ELIGIBILITY

YES

NO

- | | | |
|-----|-----|--|
| ___ | ___ | I have a hearing, visual and hearing loss, or speech disability, which prevents me from using the telephone effectively. |
| ___ | ___ | I am three years of age or older, and can demonstrate the ability to use the equipment. |
| ___ | ___ | I now have phone service or have applied for phone service in the state of Nebraska at my place of residence. |
| ___ | ___ | I am a current resident of the state of Nebraska. |
| ___ | ___ | Have you ever applied for this program? If yes, approximate month and year ____/____ |

The above facts are true and complete to the best of my knowledge.

X_____ **DATE**_____

(Applicant or Guardian's Signature if applicant is under 18 years of age)

PROFESSIONAL CERTIFICATION

(to be completed by certifier)

I certify that this applicant as one of the following:

☐ Deaf ☐ Hard of Hearing ☐ Speech Disability ☐ Deaf-Blind

(check one of the following and provide appropriate information)

- ☐ Assistive Technology Project Representative (ATP)
- ☐ Audiologist or Licensed Hearing Aid Dispenser
- ☐ Augmentative Speech Pathologist
- ☐ Center for Independent Living Representative
- ☐ Licensed Physician/Assistant
- ☐ Nebraska Commission for the Deaf and Hard of Hearing (NCDHH)
- ☐ Services for the Visually Impaired Representative (SVI)
- ☐ Speech Pathologist
- ☐ Vocational Rehabilitation Representative (VR)
- ☐ Other _____

This individual requires other adaptive equipment (specify): _____

(please print)

NAME: _____

AGENCY NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

TELEPHONE: () _____ **FAX:** () _____

E-MAIL ADDRESS: _____

X _____ **DATE:** _____

(Certifier's Signature)

(Title)

INTERNAL USE ONLY

Approved _____

Denied _____

Completed by:

NAME: _____ **AGENCY:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **Zip** _____

PHONE NUMBER: () _____

E-MAIL ADDRESS: _____

X _____ **DATE:** _____

(NSTEP Coordinator's Signature)